

Self-Direct-CFC/PAS SERVICE PLAN

<input type="checkbox"/> Intake <input type="checkbox"/> Annual <input type="checkbox"/> Amendment <input type="checkbox"/> Temporary Authorization <input type="checkbox"/> High Risk <input type="checkbox"/> Other				
MPQH Profile Date Span:			MPQH Total Profile Bi-Weekly Units (15 Minutes = 1 Unit):	
SERVICE PLAN SCHEDULE Member Name:			Medicaid ID Number:	
AM/PM	ADL Tasks	Frequency Week One	Frequency Week Two	Comments
AM/PM	HMA Tasks	Frequency Week One	Frequency Week Two	Comments
AM/PM	IADL Tasks	Frequency Week One	Frequency Week Two	Comments
AM/PM	Skill Acquisition	Frequency Week One	Frequency Week Two	Comments
Total ADL/HMA Units		Total IADL Units	Total Skill Acquisition Units	Total Bi-Weekly Units
COMMENTS AND SPECIAL INSTRUCTIONS FOR SERVICE PLAN IMPLEMENTATION:				
TEMPORARY AUTHORIZATION/AMENDMENT <input type="checkbox"/> Change In Condition <input type="checkbox"/> Change In Task <input type="checkbox"/> Change In Task Frequency <input type="checkbox"/> High Risk <input type="checkbox"/> Addition Of Skills Acquisition				
Describe ADL/IADL/HMA Change <input type="checkbox"/> Short Term <input type="checkbox"/> Permanent				
TEMPORARY AUTHORIZATION Start Date: End Date: Total Time: Date Faxed To MPQH:				
MEMBER My Plan Addresses My Personal Assistance Needs, Including Health And Welfare.				
MEMBER/PERSONAL REPRESENTATIVE			DATE	
			<input type="checkbox"/> Concur <input type="checkbox"/> Do Not Concur	
PROVIDERS <input type="checkbox"/> This Service Plan Does Not Require Completion Of A Risk Negotiation Form <input type="checkbox"/> I Agree With The Amendment Request				
SD PROVIDER SIGNATURE		AGENCY	DATE	<input type="checkbox"/> Concur <input type="checkbox"/> Do Not Concur
PLAN FACILITATOR SIGNATURE		AGENCY	DATE	<input type="checkbox"/> Concur <input type="checkbox"/> Do Not Concur
Distribution: White-Provider; Yellow- Member; Pink- Plan Facilitator				